

# THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH

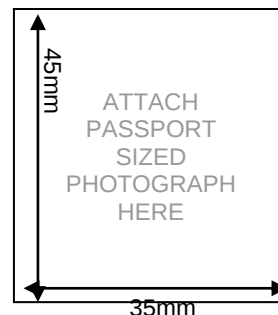
## Membership in Oral and Maxillofacial Surgery Examination

Last name of candidate: .....  
(BLOCK LETTERS)

Other names in full: .....  
(BLOCK LETTERS)

Date of birth (dd/mm/yyyy): ..... Male/Female:.....

College username (if known): .....



Full postal address: .....

.....

.....

Daytime telephone no: ..... E-mail: .....

Mobile No: .....  
(Including full international dialling code for overseas trainees)

I wish to enter the Membership in Oral and Maxillofacial Surgery Examination (MOMS RCSEd) at the following centre

Examination centre ..... Date of examination.....

### 1. Please give details of your qualifications:

Qualification

Awarding body

Date

.....

.....

.....

GDC registration number: (if applicable) .....

(Candidates whose names do not appear in the current UK Dentists Register must submit evidence of their qualifications and the date of acquisition)

### 2. Have you ever submitted an application for the Membership in Oral and Maxillofacial Surgery of the Royal College of Surgeons of Edinburgh? YES/NO

## TO BE COMPLETED BY ALL CANDIDATES

Award of the Membership in Oral and Maxillofacial Surgery RCSEd (MOMS RCSEd) is dependant on evidence that the candidate will have completed a period of three years full-time (or part-time equivalent) training in this specialty. Candidates may, however, enter themselves for examination after two and a half years (or part-time equivalent) training.

### PLEASE PROVIDE CONFIRMATION OF YOUR TRAINING BELOW

Title of post/course: .....

Post identifier No. (if applicable): .....

Dates (dd/mm/yyyy): From .....To .....

Signature of  
Specialist in charge of training: .....

Official Hospital Stamp

PRINT NAME: .....

Position held: .....

Date of signing (must be completed): .....

AND

I certify that the above named has occupied a training post as  
specified above and that all in-service assessments have been satisfactory:

Signature of Head of Hospital: .....

PRINT NAME: .....

Date of signing (must be completed): .....

Official Hospital Stamp

*Candidates who are unable to have the above sections signed must produce certified confirmation of the posts they have held and attach to this form.*

### 3. CANDIDATE CHECKLIST

#### Is your application form complete?

Failure to provide the documentation listed below may result in your application form being returned

| Have you included the following: | YES | NO |
|----------------------------------|-----|----|
|----------------------------------|-----|----|

- |                                                                    |                          |                          |
|--------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Complete and up-to-date contact information                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Two recent passport sized photographs                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Certified copy of your primary dental qualification certificate | <input type="checkbox"/> | <input type="checkbox"/> |

***If your name appears on the current UK Dentists Register a certified copy of your certificate is not required.***

- |                                                                     |                          |                          |
|---------------------------------------------------------------------|--------------------------|--------------------------|
| 4. Evidence of 3 years full time (or part-time equivalent) training | <input type="checkbox"/> | <input type="checkbox"/> |
|---------------------------------------------------------------------|--------------------------|--------------------------|

***If you are unable to obtain the signature and stamp of your Trainer or Consultant on your application form then you must submit letters or certificates confirming your posts.***

*Copies of letters and certificates will only be accepted if they have been verified as a true copy by your Trainer or authorised hospital official and stamped with the official hospital stamp. (The signature and stamp must be original.) Please also note that if the official hospital stamp is not in English applicants will be required to obtain an official English translation from a translation agency.*

- |                         |                          |                          |
|-------------------------|--------------------------|--------------------------|
| 5. Full examination fee | <input type="checkbox"/> | <input type="checkbox"/> |
|-------------------------|--------------------------|--------------------------|

***If paying by cheque, ensure that the cheque has been signed, dated and has the amount written in words and numbers. Cheques and bank / demand drafts must be drawn on a UK bank. Ensure that your name is written on the back of the cheque or draft.***

- |                                                                                                  |                          |                          |
|--------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 6. Signed and dated the declaration confirming that you have read and understood the regulations | <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------------------------------------------------------------------------------|--------------------------|--------------------------|

- |                                                                                                                               |                          |                          |
|-------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 7. Included 4 signed Declaration Forms (appendix D) and 4 signed Consent Forms (appendix E) in respect of the Case Histories. | <input type="checkbox"/> | <input type="checkbox"/> |
|-------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|

#### NOTIFICATION OF APPLICATION STATUS AND RESULT

You will automatically be kept up to date with the progress of your application by email.

- ☐ Tick this box if you would like to receive updates about your application to your mobile phone via SMS
- ☐ Tick this box if you would like your examination results to be sent to your mobile phone via SMS in addition to receiving them by post\*
- ☐ Tick this box if you would like to receive your examination results by email\*

***\* The College is working towards offering Examination results to candidates by email and/or SMS. We cannot guarantee that this will be in effect by the time your Examination result is available.***

#### CANDIDATE DECLARATION

I declare that I have read and understood the Regulations relating to the Examination for which I wish to apply and I now confirm that to the best of my knowledge all the information given on this form is a true statement of fact. I understand that success in this Examination will not automatically confer entry onto the United Kingdom's General Dental Council Specialist List. (This is dealt with by the GDC not the College).

Candidate Signature: ..... Date: .....

## **PAYMENT METHOD**

**Name of Candidate** .....

Payment must be made in full by cheque, bank/demand draft or credit or debit card. For details of current examination fees, please refer to the Examinations Database on the College website [www.rcsed.ac.uk](http://www.rcsed.ac.uk)

### **By Cheque / Draft**

Enter cheque/draft number in box provided. Cheque/draft should be made payable to: "The Royal College of Surgeons of Edinburgh"  
Please print candidate name on back of cheque/draft

|  |
|--|
|  |
|--|

### **By Credit / Debit Card**

**Important Note:** Candidates applying for an examination for which the fees are not paid in pounds sterling (GBP) or for which the application form, fees and documentation have to be sent directly to an overseas centre **cannot pay by credit or debit card**

**I wish to pay by:** VISA / MASTERCARD / SWITCH / DELTA / VISA DEBIT / SOLO / MAESTRO\*  
(\*Circle appropriate card)

**Card Number:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

**Valid From Date:**

|  |  |
|--|--|
|  |  |
|--|--|

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

  
(month) (year)

**Expiry Date:**

|  |  |
|--|--|
|  |  |
|--|--|

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

  
(month) (year)

**Debit Card Issue Number (if applicable):**

|  |
|--|
|  |
|--|

**Card Security Number\*:**

|  |  |  |
|--|--|--|
|  |  |  |
|--|--|--|

\*(Last three digits of the number found on the signature strip on the reverse of your card)

**Total Examination fee to be withdrawn from my account: £.....**

**Name of Card Holder:** .....

**Signature of Card Holder:** .....

**Date:** .....

### **Completed Applications must be posted to:**

**Examination Section  
Royal College of Surgeons of Edinburgh  
3 Hill Place  
Edinburgh  
EH8 9DS**

## **Release of Information to UK Dental Regional Advisers**

From time to time the College's Dental Regional Advisers in the United Kingdom may wish to contact you regarding your Examination application form or your performance in the Examination. If you would like the College to supply your contact information and details of your performance in the Examination to your local Dental Regional Adviser please complete the form below.

Any information given to a College Adviser upon the request of the candidate will be handled in accordance with the Data Protection Act.

### **Candidate Authorisation**

I authorise the College to release details relating to my application form and performance in the Examination to the Regional Adviser upon request:

**Candidate Name:** .....

**Candidate Signature:** .....

The tables below list the areas in which the College has Dental Regional Advisers. Please indicate with a tick (✓) the Region to which you are closest:

#### **SCOTLAND**

|                     |  |
|---------------------|--|
| Grampian            |  |
| Tayside             |  |
| Highland            |  |
| South East Scotland |  |
| West of Scotland    |  |

#### **WALES**

|            |  |
|------------|--|
| North      |  |
| South      |  |
| South East |  |

#### **IRELAND**

|                     |  |
|---------------------|--|
| Northern Ireland    |  |
| Republic of Ireland |  |

#### **ENGLAND**

|                               |  |
|-------------------------------|--|
| North West                    |  |
| Mersey                        |  |
| Eastern                       |  |
| South Yorkshire/East Midlands |  |
| West Midlands                 |  |
| Kent/Surrey/Sussex            |  |
| Yorkshire                     |  |
| Northern                      |  |
| South West                    |  |
| North Thames                  |  |
| South Thames                  |  |
| Oxford                        |  |
| Wessex                        |  |

## EQUAL OPPORTUNITIES MONITORING (OPTIONAL)

The Royal College of Surgeons of Edinburgh aims to ensure fair treatment in relation to admission and assessment of examination candidates. The College aims to assess candidates on the basis of ability, regardless of gender, colour, ethnic or national origin, race, disability, age, socio-economic background, religious or political beliefs, family circumstances, marital status, sexual orientation or other irrelevant distinction. Completing this form will allow us to monitor our statistics and ensure that we are not discriminating in any way.

In line with UK legislation and good practice guidelines, we are asking everyone to complete this section. You are not obliged to provide any of the information in this section, but if you do so, it will enable us to monitor our business processes and ensure that we provide equality of opportunity to all.

### Gender

- ☐ Female
- ☐ Male

**Nationality**.....

**1st language**.....

**Do you have a disability** under the terms of the Disability Discrimination Act 1995 (a person with a physical or mental impairment that affects your ability to carry out normal day to day activities which are substantial, adverse and long term)?

- ☐ Yes
- ☐ No

**What is your sexual orientation?**

- ☐ Bisexual
- ☐ Heterosexual
- ☐ Lesbian or Gay

**What is your religion or belief?**

- ☐ Buddhist
- ☐ Christian
- ☐ Hindu
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ Other religion/belief

Indicate a more specific category here:

### Ethnicity

Choose one selection from the list below to indicate your cultural background:

#### a) White

- ☐ British
  - ☐ Irish
  - ☐ Any other White background
- Please specify \_\_\_\_\_

#### b) Mixed

- ☐ White and Black Caribbean
  - ☐ White and Black African
  - ☐ White and Asian
  - ☐ Any other mixed background
- Please specify \_\_\_\_\_

#### c) Asian or Asian British

- ☐ Indian
  - ☐ Pakistani
  - ☐ Bangladeshi
  - ☐ Any other Asian background
- Please specify \_\_\_\_\_

#### d) Black or Black British

- ☐ Caribbean
  - ☐ African
  - ☐ Any other Black background
- Please specify \_\_\_\_\_

#### e) Chinese or other ethnic group

- ☐ Chinese
  - ☐ Any other background
- Please specify \_\_\_\_\_

Indicate a more specific category here:

This information will be recorded electronically with your other data in accordance with the Data Protection Act 1998, but used only for monitoring our business practices.